ARIZONA STATE BOXING COMMISSION
1110 W. WASHINGTON, SUITE 260
PHOENIX, ARIZONA 85007
TELEPHONE (602) 364-1721 FACSIMILE (602) 364-1703

(2008) OPHTHALMOLOGICAL EXAM (2008)

REPORT OF EYE EXAMINATION FOR PROFESSIONAL BOXER/UNARMED COMBATANT TO BE PERFORMED *BY AN OPHTHALMOLOGIST *

Full name: First Middle Last Ringname Date of Birth ___/___/___

Address (Street) City State Zip code

HISTORY: If possible provide the following information:

Name and hometown of physician in charge: _____

Has applicant ever had any of the following conditions:

(1) Blurred vision ____ Yes ___ No

(2) Surgical procedures done to his/her eye(s) or the tissues around the eye other than simple sutures of the skin around the eye? _____ Yes _____ No

(3) Has applicant ever been informed by a physician that he/she had significant eye problems such as retinal detachment, retinal tear, primary or secondary glaucoma , aphakia, pseudophakia, dislocated lens, or cataract? __ Yes ___ No If yes please explain: _____

(4) Eye disease? _____ Yes ___ No
List nature of disease: _____

(5) Eye injury: _____ Yes ____ No
List nature of injury: _____

(6) Detached retina surgery on either eye: _____ Yes ___ No
List which eye and when and where surgery was done: _____

EXAMINATION:

VISION: Without / With Glasses
Right _____/_____
Left _____/_____

REFRACTION: If either eye is 20/40 or worse:
Right____ Sph ____Cyl x _____ Acuity _____
left _____ Sph ____Cyl x _____ Acuity _____

Remarks: _____

Intraoccular Tension Right _____ mmHg
Left _____ mmHg
Motility Normal _____ Abnormal _____
Binocular vision Normal _____ Abnormal _____

SLIT LAMP EXAM	NORMAL Right / Left	ABNORMAL Right / Left	SPECIFIC ABNORMALITIES
Conjunctive			
Cornea _____	_____/_____	_____/_____	_____
_____ _____	_____/_____	_____/_____	_____
Iris/Pupil _____	_____/_____	_____/_____	_____
Lens _____	_____/_____	_____/_____	_____
Eyelids _____	_____/_____	_____/_____	_____

INDIRECT OPHTHALMOSCOPY WITH SCLERAL DEPRESSION (Dilated Pupil)

	NORMAL Right / Left	ABNORMAL Right / Left	SPECIFIC ABNORMALITIES
Disc _____	_____/_____	_____/_____	_____
Macula_____	_____/_____	_____/_____	_____
Vessels_____	_____/_____	_____/_____	_____
Peripheral Retina _____	_____/_____	_____/_____	_____

THE COMMISSION WILL ONLY ACCEPT ORIGINAL EXAM SIGNED AND DATED BY OPHTHALMOLOGIST
(PLEASE READ AND SIGN ON REVERSE SIDE OF EXAM)

REPORT OF EYE EXAMINATION FOR PROFESSIONAL BOXER / UNARMED COMBATANT BY AN OPHTHALMOLOGIST
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OPHTHALMOLOGIST REMARKS:

_____
_____
_____
_____

The Commission may deny, suspend, revoke, or place restrictions on the license of a professional boxer or martial arts fighter because of a medical or visual condition, (The Commission may also place restrictions for the same medical conditions on all amateur combatants under its jurisdiction) including but not limited to the following:

1) Uncorrected visual acuity of less than 20/200 in either eye or 20/60 with both eyes;
2) Corrected visual acuity of less than 20/60 in either eye, regardless of its cause;
3) A visual field of 60 degrees or less extending over one or more quadrants of the visual field;
4) Presence or history of retinal detachment or retinal tear unless treated by an ophthalmologist and then approved by an ophthalmologist specified by the Commission who then assesses that the boxer is at no significant risk of further injury to the retina if boxing is resumed. Such assessment shall occur both within five days before and five days after the contest;
5) Presence of primary or secondary glaucoma, whether or not such condition has been treated;
6) Presence of aphakia, pseudophakia, dislocated lens or cataract in either eye;
7) Any other visual condition which the Commission determines would prevent the applicant or licensee from safely engaging in boxing activities.

The examining physician is requested to mail a copy of any report, directly to the Commission of an applicant that has a condition that may preclude him/her from being licensed or cleared to participate in boxing activities.

OPHTHALMOLOGIST:
I have read the above criteria and, in accordance with the vision requirements as stated therein, have examined the applicant named on the other side of this form and I ____ **DO NOT FIND** _____ **DO FIND** a condition that would preclude him/her from being licensed or cleared to participate as a _____ professional boxer _____ unarmed combatant.

_____ _____
LICENSED OPHTHALMOGIST NAME AND LICENSE NUMBER (please print) OPHTHALMOLOGIST SIGNATURE

_____ _____
STREET ADDRESS DATE

_____ (_____)_____
CITY STATE ZIP CODE PHONE NUMBER

_____
SIGNATURE OF CONTESTANT

ANY ATTEMPT TO ALTER OR FALSIFY THIS DOCUMENT WILL RESULT IN FORFIETURE OF LICENSE AND/OR PROSECUTION IN A CRIMINAL COURT OF LAW.

EXAMINATIONS BY AN OPTOMETRIST WILL NOT BE ACCEPTED

OPTOMETRISTS PLEASE DO NOT COMPLETE EXAMINATION